Racism and Health Inequity among Americans

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Research reports often cite socioeconomic status as an underlying factor in the pervasive disparities in health observed for racial/ethnic minority populations. However, often little information or consideration is given to the social history and prevailing social climate that is responsible for racial/ethnic socioeconomic disparities, namely, the role of racism/racial discrimination. Much of the epidemiologic research on health disparities has focused on the relationship between demographic/clinical characteristics and health outcomes in main-effects multivariate models. This approach, however, does not examine the relationship between covariate levels and the processes that create them. It is important to understand the synergistic nature of these relationships to fully understand the impact they have on health status.

Purpose: A review of the literature was conducted on the role that discrimination in education, housing, employment, the judicial system and the healthcare system plays in the origination, maintenance and perpetuation of racial/ethnic health disparities to serve as background information for funding Program Announcement, PA-05-006, The Effect of Racial/Ethnic Discrimination/Bias on Healthcare Delivery (http://grants.nih.gov/grants/ guide/pa-files/PA-05-006.html). The effect of targeted marketing of harmful products and environmental justice are also discussed as they relate to racial/ethnic disparities in health.

Conclusion: Racial/ethnic disparities in health are the result of a combination of social factors that influence exposure to risk factors, health behavior and access to and receipt of appropriate care. Addressing these disparities will require a system that promotes equity and mandates accountability both in the social environment and within health delivery systems.

Key words: racism ■ healthcare ■ race/ethnicity ■ minorities ■ disparities

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BACKGROUND

Racial/ethnic minorities suffer disproportionate morbidity and mortality from chronic diseases, such as cancer, heart disease, diabetes and stroke. Although racial/ethnic differences in morbidity and mortality can be partially explained by differences in lifestyle, health-seeking behavior and financial access to care, these factors do not entirely explain differences in incidence, treatment or outcomes. A recent report from the Institute of Medicine (IOM) on unequal medical treatment,[1] as well as several other recent articles and reviews,[2-4] shows that racial/ethnic minorities also less frequently receive appropriate care, which has an adverse impact on their health outcomes. According to one recent report, racial equity between African Americans and whites in the receipt of healthcare with existing treatment modalities would save five times more lives than technological advances, such as new drugs, devices and procedures.[5] This is supported in part by a recent study, which showed that African-American Medicare beneficiaries have lower access to new procedures because of their receipt of care in hospitals that have lower procedure rates.[6] Although research reports often cite socioeconomic status as an underlying factor in the pervasive disparities in health observed for racial/ethnic minority populations, little information or consideration seems to be given to the social history and prevailing social climate that contribute to racial/ethnic socioeconomic disparities—namely, the role of racism/racial discrimination.

The IOM committee report recognized the role that racism/discrimination plays in healthcare delivery stating: 1) "Racial/ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life; 2) health systems, healthcare providers, patients and utilization managers may contribute to racial and ethnic disparities in healthcare; and 3) that health provider bias, stereotyping, prejudice and clinical uncertainty may contribute to racial and ethnic disparities in healthcare." A more recent report from a Trans-U.S.

Department of Health and Human Services Health Disparities Progress Review Group[7] recognized the importance and need to discuss societal racism as a fundamental cause of health disparities.

See and Wilson[8] describe two components of racism: 1) an ideology that justifies social avoidance and domination of a particular minority group and 2) a set of norms that prescribes different treatment. Racial discrimination is described by the National Research Council as: 1) "differential treatment on the basis of race that disadvantages a racial group" and 2) "treatment on the basis of inadequately justified factors that disadvantages a racial group."[9] For the purpose of this discussion, race is defined as a continuously evolving social construct used to categorize individuals into groups that have typically been based on the physical characteristics (e.g., skin color, hair texture or other distinctive characteristics, etc.) of an individual or his/her ancestors.[10] Ethnicity refers to cultural groups that have been typically defined by a common language, religion, nationality or heritage.[11]

Racism occurs at three basic levels: 1) institutional, 2) personal and 3) internal.[12] Institutional racism occurs when seemingly innocuous policies and practices result in the disproportionate harm to particular race/ethnic groups. Institutional racism doesn't require intent but is inherent in its outcome.[13] Personal or individualized racism refers to personal prejudice resulting from negative attitudes and/or beliefs about a particular racial group's motivations, abilities and intentions.[14] It too does not require intent and as Jones states[12] can be an act of either commission or omission. Internalized racism occurs when members of the stigmatized group accept or internalize the negative messages and stereotypes regarding their race/ethnic group that are perpetuated in society.[12] This form of racism affects how one perceives himself/herself, including his or her self-worth and influences acceptance/tolerance of racially biased treatment or maltreatment by others.

Racism persists in American society because beliefs and attitudes that are not blatantly racist but result in racist behavior or outcomes are often not perceived to be racist. As Parks[15] states, "racism thrives on denial". Although the number of U.S. hate crimes has declined in general, crimes motivated by race and ethnicity still comprised 48.8% and 14.8% of the 7,459 hate crimes reported in 2002, respectively.[16] Racism is not always directed towards a minority group, although 58% of African-American respondents to the 1995 National Survey of Functional Health reported ever having one or more experiences with racial discrimination compared to only 10% of whites.[17] It is also worth noting that among African Americans, reported experiences with racial discrimination increased with increasing levels of education, while the opposite was true for whites. Individualized or interpersonal racism today is most apparent in the prevailing stereotypes and societal attitudes towards particular race/ethnic groups.[18] Data from the 1990 and 2000 General Social Survey (GSS) show that minorities continue to be viewed more negatively than whites.[19,20] For example, only 20% of white survey respondents to the 1990 GSS indicated that they believed that African Americans were intelligent, 13% that they prefer to be self-supporting, 17% that they were hardworking and 15% that they were not prone to violence.[21] These attitudes carry over into social and professional interactions and unfortunately, influence individual perceptions, behavior and decision-making. Victim-blaming, rationalization, minimalization and denial of racist behavior impedes the understanding and amelioration of the social inequalities that underlie racial/ethnic inequities in health.[21]

Much of the epidemiologic research on health disparities has focused on the relationship between demographic/clinical characteristics and health outcomes in main-effect multivariate statistical models. This approach, however, does not examine the relationship between covariate levels and the social processes that create them. The importance of examining these relationships lies with the ability to understand how they work in concert to influence health status, which is essential for the design and implementation of programs that are effective in altering the social dynamics of health disparities. Therefore, a review of the literature was conducted as background to the formulation of a new Program Announcement, PA-05-006, The Effect of Racial/Ethnic Discrimination/Bias on Healthcare Delivery (http://grants.nih.gov/grants/guide/pa-files/PA-05-006.html).

The conceptual framework developed by Krieger[22] is used to frame the current discussion. Krieger describes five key pathways through which racism is hypothesized to contribute to racial/ethnic health disparities. These include increased exposure and susceptibility to: 1) economic and social deprivation; 2) toxic substances and hazardous conditions; 3) socially inflicted mental and physical trauma directly experienced or witnessed; 4) targeted marketing of potentially harmful commodities, such as tobacco, alcohol and illicit drugs; and 5) inadequate or degrading medical care.

RACISM AND THE SOCIAL ENVIRONMENT

Economic and Social Deprivation

The economic power required for achieving and maintaining good health remains elusive for many members of racial/ethnic minority groups who have been historically denied full access to socioeconom-

ic resources. Thus, it is not surprising that in 1999 the median family income for American Indians/Alaska Natives, African Americans and Hispanics was more than 60% lower than that of non-Hispanic whites.[23] More than 24% of African Americans and 22.5% of Hispanics live in poverty compared to only 8.2% of non-Hispanic whites.[24] Housing, education and employment are intricately linked to the ability to access needed resources and help to define available choices. The judicial system also contributes to health disparities through its influence on socioeconomic opportunities, healthcare access and harmful exposures.

Housing

Thirty-six years after the passage of the Fair Housing Act in 1968,[25] discrimination remains a significant problem for racial/ethnic minorities.[26] Although there has been an increase in annual income for African Americans, decreases in black-white segregation rates in general are not due to an overall movement of African Americans to segregated white areas.[27] Hispanics and African Americans are often directed to highly segregated minority and poorer neighborhoods (i.e., higher crime rates, poorer schools) than whites of similar socioeconomic status.[28] Hispanics are also frequently quoted higher rates than non-Hispanic whites for rental of the same unit.[26] Data from audit testing programs[29] provide evidence of geographic steering and discrimination in the mortgage pre-application process,[30,31] mortgage lending, home insurance and in the rental market.[31,32] The U.S. Department of Housing and Urban Development (HUD) estimates that there are more than two million incidents of housing discrimination each year, many of which are not reported.[30] In 2003, racial/ethnic discrimination was the basis for 50% of the housing discrimination complaints filed with HUD.[33] Residential segregation as a result of discriminatory housing practices has been identified as a contributor to racial/ethnic health disparities[34,35] because of its association with poorer access to essential social, economic, physical[36,37] and educational resources,[38] particularly when it is also associated with high levels of poverty. Since community resources are primarily determined by home values on which community taxes and consequently resources are based, the concentration of minorities in areas where homes have less value also concentrates them in areas with fewer resources. This has a direct influence on the accessibility, quality, cost and convenience of accessing other basic needs and services, for example, the availability, selection and quality of food,[39,40] quality of public schools,[41,42] physician supply[43] and employment opportunities.[44]

A disproportionate amount of the health risks incurred by minority children and elderly persons are a result of residence in "substandard" or older housing,[45] which is often characterized by the prevalence of poor indoor air quality, inadequate heating/cooling, electrical and other fire hazards, rodent and pest infestation, structural problems and the presence of lead-based paint.[46] Data from NHANES III show that African-American (11.2%) and Mexican-American (4.0%) children have a higher prevalence of lead poisoning than do white children (2.3%).[47] Several studies also show an association between chronic exposures to indoor allergens and the development or exacerbation of asthma and other allergen-related respiratory diseases,[48-50] which disproportionately affect racial/ethnic minority children.[51]

Education

Racial/ethnic disparities in education completion levels contribute to the lower socioeconomic status of some minority populations and, as a consequence, their health. U.S. high-school completion rates in 2001 ranged from a low of 50.2% for African Americans to 76.8% for Asians/Pacific Islanders.[52] When stratified by gender, however, greater racial/ethnic disparities are observed among males with high-school completion rates that range from 42.8% for African Americans to 72.6% for Asians/Pacific Islanders. Racial/ethnic disparities in education achievement are the result of a combination of factors, including the environment, disincentives, poorer quality educational programs and racist institutional policies and practices. For example, racism has been implicated in the disproportionate labeling, identification and placement of minority students into special education programs,[53-56] particularly for disabilities that are based on more subjective measurements (e.g., emotional disturbance, specific learning disabilities and mental retardation) and stigmatizing categories than for medically diagnosed disabilities. Although poverty is often mentioned as an underlying factor, a recent study of Arizona public schools showed that male minority students attending schools that were 75% or more white were 64% more likely to be labeled as emotionally disturbed, mentally retarded or to be labeled as having specific learning disabilities than minority males attending schools that have fewer whites, despite being less likely to have grown up in poverty. It is interesting to note that white male students that attended schools that were 75% or more white were 50% less likely to be placed in special education classes than if they attended schools with fewer whites.[54] Similar results were found in an analysis of Pennsylvania public schools.[53] A Department of Education report noted that students labeled as having learning disabilities are 20% more likely to drop out than students not labeled as such and those labeled as

emotionally disturbed are three times more likely to drop out than students with physical disabilities.[57]

The use of racially biased standardized testing for high-school graduation and for college admission further disadvantages minority students. These tests, conceptually at least, have to be premised on the assumption that test takers have received a "standard" education and have had "standard" experiences. Nonetheless, several studies provide evidence of the poorer educational environments of minority students, including having fewer and less experienced teachers, fewer certified teachers and higher teacher turnover rates, particularly for those who reside in the inner cities.[58] The College Board, which owns several standardized tests used for college admissions including the SAT and GRE, concluded in a 1999 report that the small numbers of African Americans, Hispanics and Native Americans among top students is the result of several factors, including economic circumstances; level of parent's education; racial/ethnic prejudice and discrimination; and quality, amount and use of school resources.[59] Recent changes from race-sensitive affirmative action college admission policies have resulted in a decrease in minority enrollment at several state universities, particularly at flagship schools.[60-63] It is also worth noting that in October 2004, the unemployment rate for high-school dropouts was nearly twice the rate for high-school graduates that did not go to college.[64]

Research studies show a consistent association between education, health behavior and health status.[65] For example, individuals with lower education achievement levels have a higher prevalence of chronic disease risks,[66,67] poorer health outcomes,[68] lower compliance with cancer screening recommendations[69-71] and are more frequently diagnosed with advanced disease.[72]

Employment

Evidence from random testing of the employment application process shows persistent racism in employment and hiring practices.[73] Despite being equally qualified, African-American and Hispanic women receive fewer interviews and job offers than white applicants. It is not surprising then that African Americans are disproportionately represented among the unemployed. The seasonally adjusted unemployment rate for the 3rd quarter 2004 for African Americans (10.5%) is more than twice the rates for whites (4.6%).[74] It is worth noting that unemployed African Americans, less frequently than whites, are unemployed because they voluntarily left their jobs or are on temporary layoff.[75] Interpersonal prejudice is also operative in the postemployment environment and impedes minority employee advancement, recognition as viable members of the organization and interferes with minority job satisfaction. More than 28,000 charges of race-based employment discrimination were filed in fiscal year 2003.[76] Research studies show that professional African-American men earn 79% and African-American women earn only 60% of the salaries earned by white males with the same education and in the same job categories.[77] Data from the Current Population Survey show that African Americans had the lowest real median household income of all the race/ethnic groups reported for 2003.[78]

Persistent disparities in employment opportunities contribute to racial/ethnic disparities in health not only because of the association with access to financial resources but also with access to health insurance and because of the stress discrimination causes[79] Approximately 60% of insured Americans are covered by employment-based health insurance plans.[78] The disproportionate decrease in employment-based health insurance coverage because of the higher unemployment and lower paying jobs among racial/ethnic minorities contribute to racial/ethnic disparities in health insurance coverage[80] and consequently, their access to timely and appropriate healthcare.

The U.S. Judicial System

An increase in the U.S. prison population as a result of drug policy changes has also had a disproportionate impact on racial/ethnic minority populations.[81] Nationwide, African Americans are incarcerated at a rate that is 8.2 times that observed for whites. In 1990, African Americans represented 29% of all arrests and 47% of all incarcerations, while whites represent 69% of the arrests but only 48.2% of the incarcerations. Seventy-two percent of illicit drug users are white, 15% are African American and 10% are Hispanic,[82] yet drug offenses account for 27% of the growth in the African-American, 7% of the growth in the Hispanic and 15% of the growth in the white prison populations under state jurisdiction from 1990 through 2000.[83] African Americans more frequently than whites are arrested for drug possession[84] and receive prison sentences for convictions for felony drug possession[85] and life sentences for illicit drug use under the three-strike rule.[86] Differential sentencing previously mandated by the Anti-Drug Abuse Act for possession of drugs for which minority drug users are more frequently prosecuted (i.e., crack cocaine) is a major contributor to the disproportionate incarceration rates. Per one report, an individual would have to possess 500 g of powdered cocaine to get the five-year sentence mandated for the possession of 5 g of crack cocaine.[87] These drug policies have had a disproportionately high impact on racial/ethnic minority women. For example, Hispanic and African-American women comprised, respective-

ly, 44% and 39% of state prison inmates serving sentences for drug related offenses, compared to only 23% of white women and 26% and 24% of Hispanic and African-American men.[88]

Racial/ethnic disparities in prosecutions and prison incarceration rates are associated with the health of minority populations in a variety of ways.[89,90] For example, approximately 80% of the women prosecuted for drug use during pregnancy are minorities. Respondents in a recent survey of 142 mostly minority women indicated that punitive laws would be a deterrent to seeking prenatal care, drug testing and treatment for pregnant, substance-abusing women.[91] It is worth noting that infant mortality rates for African Americans in 2002 were twice the national average.[92] Minority incarceration also interferes with family formation and cohesiveness and diminishes the family income and post-release earning capacity of the inmate, which may result in an increase in the rate of poverty among affected families and children. The disproportionate incarceration of African-American males is estimated to increase African-American child poverty rates up to 28% for each percentage point increase in the African-American male incarceration rate, depending upon the educational level of the mother and whether or not the father resided with the family prior to incarceration.[89] The association between poverty and poor health is well documented.[93-98]

Rates of HIV, tuberculosis, hepatitis, sexually transmitted diseases and substance abuse are higher among inmates in correctional facilities than among the general U.S. population.[99,100] It is estimated that 14% of intravenous drug users in the 96 largest U.S. cities are HIV positive.[101] In one report, 78% of drug-injecting inmates reported sharing drug-injection equipment while in prison.[102] Many prison inmates do not receive adequate or timely medical care and eventually return to the community with their health problems.[85,103] Further complicating the problem is legislation that bars access to federal benefits, including healthcare, housing and assistance for higher education.[104] Although the initial intent of the "One Strike Rule"[105] was to ensure safe housing for residents of public housing, it also allows public housing authorities to more broadly screen and to evict tenants for drug or other criminal activity irrespective of the tenant's knowledge or participation in the activity, whether or not the accused resides with the tenant in the public housing unit or has been found guilty of the charge.[106] The Personal Responsibility and Work Opportunity Act of 1996, which abolished Aid to Dependent Families and Children (ADFC) also permanently barred convicted drug felons from receiving Temporary Assistant to Needy Families (TANF) and food stamps unless opposing legislation was implemented by the individual states. Only 11 states and the District of Columbia have fully opted out of the ban on access to food stamps.[107] As Welter points out, the denial of food stamps and housing assistance to individuals with a felony drug conviction is not insignificant. Families of these individuals may be forced to stretch available resources, including any benefits to which they are entitled and from which the felon is barred to cover the needs of the barred individual and other family members, thus placing additional hardship on the families.

Exposure to Disease-Causing or -Promoting Agents in the Environment

Racial/ethnic minorities are disproportionately exposed to environmental toxins, chemicals and contaminants in their community, workplaces[108] and schools.[109-114] Seventy-one percent of African Americans lived in counties that were in violation of federal air pollution standards during 2002, compared to 58% of whites. An analysis of data from the Massachusetts Department of Environmental Protection, U.S. Environmental Protection Agency and the Massachusetts Toxics Use Reduction Institute show that communities where minorities comprise 25% of the population or more have a cumulative hazardous facilities exposure rate that is almost nine times that of communities where minorities comprise 5% or less of the population.[109] This includes higher exposures to hazardous waste sites, landfills, industrial pollutants and toxic chemical emissions. Similar results were reported by Perlin et al.[113] who found that African Americans in three geographic regions (Baltimore, MD; Baton Rouge, LA; and Kanawha Valley, VA) lived closer to Toxic Release Inventory (TRI) facilities (i.e., facilities required to report location, storage and release of toxic chemicals) than whites of similar socioeconomic status. Data from another study, however, did not find a statistically significant association of health outcomes with proximity to a TRI.[115] Other research shows that pregnant Hispanic, African-American and Asians/Pacific Islander mothers are exposed to higher mean levels of air pollution and are twice as likely to live in the most polluted counties.[114] African Americans have a 22% higher prevalence of asthma and are about three times more likely to have an asthma-related emergency department visit or hospitalization and nearly three times more likely to die from asthma[51] than whites. Forty-six percent of the 3-4 million children at risk of exposure to lead at levels believed to be toxic are African-American.

Targeted Marketing of Harmful Products

The American College of Physicians lists the disproportionate marketing of unhealthy products, such

as tobacco, alcohol and high-fat foods to racial/ethnic minority communities as a major contributor to the disparate health of minorities.[80] Targeted marketing of tobacco and other harmful products contributes to the disparate health of minority populations through their influence on the initiation and promotion of the regular use of these products. The Federal Trade Commission estimates that tobacco advertising and promotion totaled $11.2 billion dollars in 2001.[116] A disproportionate amount of tobacco advertising expenditures represent money spent on advertising and promotions that target minority communities. Furthermore, the reliance of the African-American media on revenue from tobacco companies contributes to African-American exposure to tobacco advertisements through both traditional and nontraditional modes of advertising, such as free samples, coupons and sponsorship of cultural, sports or entertainment events. Approximately 60% of advertising in African-American newspapers are tobacco advertisements.[117]

There are consistent reports of the tobacco industry's targeting of minority populations.[118] For example, a Chicago study showed a higher number of billboards advertising tobacco products in minority neighborhoods compared to nonminority neighborhoods. Stoddard et al. also showed that more "ethnically tailored" advertisements appear in minority neighborhoods than in white neighborhoods.[118] There is also targeting of more harmful products.[119] About 75% of African-American smokers smoke mentholated cigarettes,[120] which have been suggested to be more harmful and addictive than nonmentholated cigarettes. Mentholated cigarettes are disproportionately marketed to African Americans and other racial/ethnic minority groups.[120] It is not surprising then, that African Americans also experience a disproportionate number of smoking-related deaths from oral, esophageal and lung cancers, coronary disease and cerebral vascular disease.[121]

Data from a recent survey of eight television show suggest that African Americans may also be disproportionately exposed to television advertisements that market unhealthy foods, such as carbonated beverages, candy and other high-sugar desserts.[122] The prevalence of obesity among African-American, Hispanic and American-Indian populations is 20–39% higher than rates among whites.[123] Approximately 112,000 deaths among Americans each year are attributable to obesity.[124] Overweight and obesity increase the risk of diabetes, heart disease, some cancers, stroke, arthritis, respiratory diseases and psychological disorders.[125]

Racism and Mental Health

Racial/ethnic discrimination also influences the health of racial/ethnic minorities through its association with mental and physiological changes and through its influence on participation in high-risk behaviors, such as excessive alcohol consumption and substance abuse. Racism influences available opportunities and behavior in social situations and as a consequence can be a significant source of stress for racial/ethnic minorities.[126-127] Several studies have examined the effect of racial bias on mental health and, in general, show that racial discrimination is associated with poor self-accessed mental health[128] and a decreased sense of well-being, including self-esteem, happiness and life satisfaction and increased psychosis, hopelessness, anxiety, anger and substance abuse.[129] Perceived discrimination has also been found to be associated with depression.[130] In a recent review of the literature, 20 of 25 studies showed a positive association between discrimination and psychological distress as did all but one of the 14 studies that examined racism and psychological well being, self-esteem or perception of mastery/control.[131]

Racism and Physical Health

Studies that have examined the influence of self-reported experiences with racism and physiologic changes have provided inconsistent results.[132-133] Some studies have shown an association between discrimination-related stress and increases in blood pressure,[22,134] while others have not.[135-136] Other research suggests that the association between perceived racial discrimination and increases in blood pressure is dependent upon coping styles.[22] A few studies have also shown that individuals that experience discrimination and other sources of stress have a higher prevalence of chronic disease behavioral risks, such as cigarette smoking[137-140] and alcohol or other substance abuse.[141-142]

RACISM IN THE HEALTHCARE SETTING

Racism and the Receipt of Inadequate, Degrading or Inappropriate Healthcare

Unfortunately racism doesn't always stop at the door of medical institutions. The influence of non-clinical characteristics, either actual or perceived, on provider perception of racial/ethnic minority patients might also have an impact on the healthcare received by patients.[143-146] Physician recommendations and referrals have been shown to contribute to racial disparities in referrals for kidney transplantation[147] and receipt of some cardiovascular procedures.[148] Several mechanisms through which providers potentially contribute to racial/ethnic disparities in health have been suggested.[149] These include provider bias against racial/ethnic minorities, uncertainty in their interactions with minority

patients, beliefs or stereotypes regarding the health behavior of minority patients and patient response to perceived provider mistreatment or other negative racial experiences. Twenty percent of Asians, 19% of Hispanics and 14% of African-American respondents to the Commonwealth Fund 2001 Healthcare Quality Survey reported being treated with disrespect or being looked down upon during a patient–provider encounter.[150] In another report, 63% of the 76 participants in a cross-sectional survey indicated that they had experienced discrimination in their interactions with their healthcare provider because of their race or color.[151] Similarly, 29% of African Americans and more than 10% of Latino/Hispanic, Filipino and Korean respondents in the King County (Seattle, WA) Health and Ethnicity Survey of 1995-1996 reported that they had experienced discrimination when seeking or obtaining healthcare due to their race or ethnicity.[152] In interviews conducted among African Americans after the survey, perceived discriminatory experiences reported by participants included differential treatment, negative attitudes, being treated as if they were unintelligent, being ignored, inappropriate allegations and racist remarks.[152]

Negative experiences in the healthcare setting may profoundly impact attitudes towards receiving care and influence further utilization of healthcare services. Data from the National Comorbidity Study show that although African Americans had more favorable attitudes towards seeking mental health services than whites prior to using them, the reverse was true after using them.[153] In the Hobson study,[152] nearly 27% of African-American respondents reported that as a result of a discriminatory event, they were more hesitant to seek health services, 25.6% avoid the healthcare facility, 23.1% avoid the provider, 15.4% stopped using specific services, 10.3% avoid the personnel involved and 7.7% use services less frequently while only 25.6% did not change their behavior.[152] Data from the Commonwealth Heath Survey also show that respondents who felt that they were treated unfairly because of their race were more likely to be noncompliant with physician advice and delayed receiving needed medical care.[150]

DISCUSSION

The reviewed literature suggests that racial discrimination against minority Americans has fostered a multigenerational cycle of poverty that has been difficult for some to break. It begins with racial prejudice, stereotyping and mislabeling of minority students in educational systems resulting in lower expectations, sense of belonging and educational achievement levels. Educational achievement in turn affects employment opportunities and access to resources, such as appropriate housing, nutrition and health insurance. Social problems that are more prevalent among poor communities, such as crime and drug abuse restrict minorities who live in these neighborhoods to their homes and often rob minority children of household income, parents or other primary caretaker and diminish the sense of security and well being of the residents. Children are desensitized to the violence that is characteristic of neighborhoods that experience these social problems, leading to pessimism towards the future and increased vulnerability to prevailing social problems. The contextual environment, including the racial/ethnic composition; level of poverty; crime rates and other social indicators; available resources; and the built environment are increasingly recognized as major contributors to disparities in health.[7,14] Individuals who manage to escape this cycle are then faced with unequal opportunities that interfere with receipt of the benefits received by whites with similar achievements and, as a consequence, wealth building, health status and quality healthcare.

The failure to address differences in the behavior towards and opportunities afforded to racial/ethnic minorities contribute to the inability to eliminate racial/ethnic disparities in health. Too often, programs designed to eliminate disparities focus on educating the community without regard for their environment and other circumstances that restrict their freedom of choice and opportunities. Addressing racism as it relates to racial/ethnic health disparities requires an assessment of its prevalence and an understanding of the specific manner in which it operates, not only in the social environment, but in healthcare delivery systems as well. Derman-Sparks et al. state, "Recognizing racism involves acknowledging beliefs, attitudes and symbols that are legitimized by those with cultural and political power and are socialized in successive generations."[154]

The IOM committee recommended that research be conducted that provides further elucidation on: 1) patient, provider and institutional contributions to healthcare disparities; 2) the relative contributions of provider bias, stereotyping, prejudice and uncertainty to racial/ethnic disparities in diagnosis, treatment and outcomes of care; and 3) the role of nonphysician healthcare professionals, pharmacists, allied health professional and nonprofessional staff in contributing to healthcare disparities.

In response to this recommendation, the National Cancer Institute (NCI), in collaboration with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), Office of Behavioral and Social Science Research (OBSS), National Heart Lung and Blood Institute (NHLB), The National Institute for Biomedical Imaging and Bioengineering (NIBIB) and The National Institute on Drug Abuse (NIDA) announce a new program to

encourage the study of the role of racial discrimination and racial/ethnic health disparities in healthcare delivery (http://grants1.nih.gov/grants/guide/pa-files/PA-05-006.html). This program announcement is designed to: 1) improve the measurement of racial /ethnic discrimination in healthcare delivery systems through improved instrumentation, data collection and statistical/analytical techniques; 2) to enhance understanding of the influence of racial/ethnic discrimination in healthcare delivery and its association with disparities in disease incidence, treatment and outcomes among disadvantaged racial/ethnic minority groups; and 3) to reduce the prevalence of racial/ethnic health disparities through the development of interventions to reduce the influence of racial/ethnic discrimination on healthcare delivery.

CONCLUSION

Racial/ethnic disparities in health are the result of a combination of social factors that influence financial access and receipt of appropriate care. Addressing these disparities will require a system that promotes equity and mandates accountability both in the social environment and within health delivery systems.

ACKNOWLEDGEMENTS

The authors thank Martin Brown, PhD for his careful review of various drafts of this manuscript and Rachel Ballard-Barbash, MD, MPH for her review of the final manuscript draft.

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